Preparing for ICD-10:
Are You Ready for Implementation? It's Not Too Late.

- Webinar begins at 11:00 a.m. central time (no sound until then)
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- Question? Please send a chat to the host.
- Today's presentation is informational only - no credit available.

Sharon Roeder, CPC
Manager of Payer Coding Compliance, vRad

June 18, 2015

Welcome

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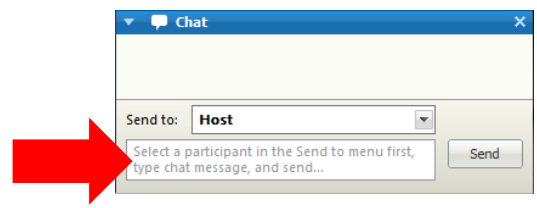

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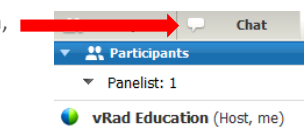

Welcome

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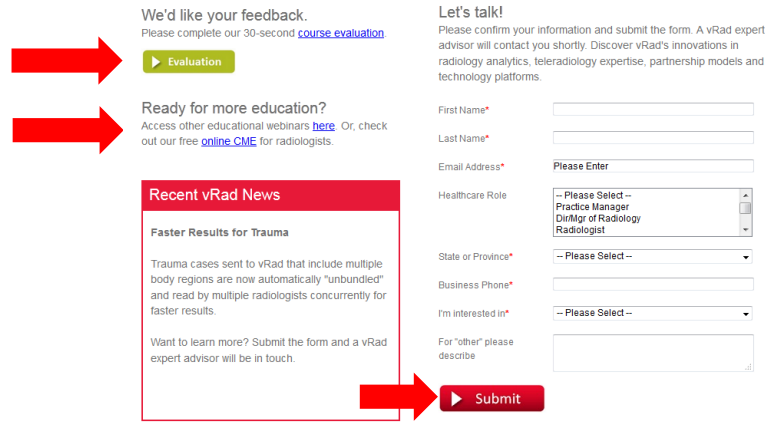

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Preparing for ICD-10-CM

Are You Ready for Implementation? It's Not Too Late.

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Sharon Roeder, CPC
Manager of Payer Coding Compliance, vRad

June 18, 2015

Disclaimer

- This presentation is designed to provide participants with reimbursement and coding related news, updates and guidance.
- The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted.
- The information, while accurate, to the best of our knowledge, at the time of production, may not be current at the time of use.
- Information is provided as general guidance only and is not a recommendation for a specific situation. Viewers should consult official sources (CMS, ACR, AMA) or a qualified attorney for specific legal guidance.
- Information provided is based on Medicare Part B billing guidelines and may or may not pertain to Medicare Part A billing. Viewers should consult their Part A – Medicare Administrative Contractor website for hospital billing guidelines.

Our Agenda

- It's not too late to take proactive action
  - Be smart and focus your final push on areas where the results will have the largest positive impact
  - Strategies for gathering clinical details from referring physicians and departments
  - Training key staff and radiologists
  - Documentation tool examples

"ICD-10 is a greatly intuitive system. If we know stuff about our patient, there's probably a code for it. Describe the patient's symptoms or diseases as you'd talk about them with a family member or with your office manager. Identify the cause of a disease and identify the effects of that disease on other body parts. And there are codes for most of these. Not a big deal."

Dr. Roberts S. Gold, M.D.
AAPC Tips & Resources
Issue 58, April 10, 2015

Dr. Gold is founder of DCBA, Inc. which is a consulting company in Atlanta that provides physician-to-physician education for documentation improvement programs nationwide.

Tell the Story

Location:

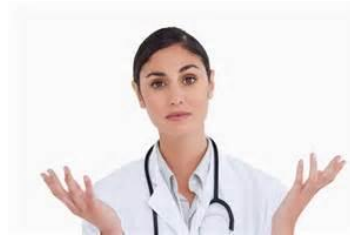
- Specific anatomical site
- Laterality / Quadrants / proximal or distal

Context:

- Timing: Onset date / duration /recurring / active treatment, during healing phase, or due to complication
- Injury: is the exam to help with diagnostic or treatment decisions OR is exam to evaluate healing process?
- Cause(s) of the symptoms or condition
- Chronic, acute, transient?
- Severity of the symptoms/condition
- Stage, status, or type of the disease

Associated or Concurrent Condition:

- Existing disease/condition that contribute to the symptoms/condition
- Pregnant? (Start date of the Last Menstrual Period)
- Medical history pertinent to exam (personal /family)



"How can we provide clinical details on our orders and radiology reports if the referring physician does not provide us with detailed indications? This is out of our control!"

There are only 104 days left to prepare!

Have you resigned your fate to your referring physicians?

How are you going to take control of getting more specific clinical details from your referring resources?

It is not too late!

Capturing Clinical Details in the Order Intake Process

Capture the Details in Study Orders and Final Reports

Where is the clinical documentation coming from?

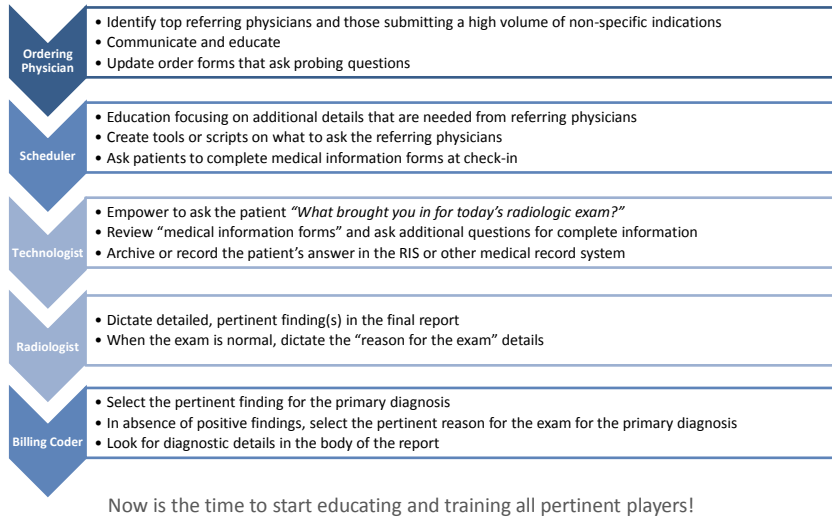
- Referring physicians and in-hospital referrals (ER, hospitalists, nurses)
- Schedulers
- Technologists
- Radiologists

How can we ensure that the clinical details make it from the referring physician to the radiology report?

Are the key people receiving ICD-10 training? Do they have helpful tools?

The radiologist does not necessarily have a face-to-face interaction with the patient. The radiologist must rely on the referring physician and the technologist who is performing the exam to provide the patient's story. Therefore, the story must be included in both the orders and final report.

From the Order to the Claim



Now is the time to start educating and training all pertinent players!

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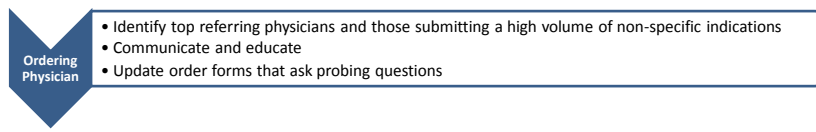
Ordering Physicians



- Identify highest volume of procedures and associated billed ICD-9 codes
  - Identify non-specific codes
  - Identify what documentation is lacking for ICD-10
- Create an inventory of physicians who refer a high-volume of patients
  - Identify those providing a high-volume of non-specific indications
  - Identify those providing non-specific indications, such as "rule-out"
- Don't forget the Emergency Room as a referring source
- Communicate with these referring physicians now and after October 1

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Step 1: Focus on High Volume Non-specific Codes

Diagnosis	Volume	Code Description	Additional Clinical Information for ICD-10-CM
786.50	48,707	Chest pain, unspecified	LOCATION: chest wall, intercostal, precordial CONTEXT: On respiration, cause of pain CONCURRENT CONDITION: COPD, Cancer (type)
793.19	45,490	Other nonspecific abnormal finding of lung field	LOCATION: Rt, Lt, superior, middle, or inferior lobe CONTEXT: Nodule, shadow, associated symptoms CONCURRENT CONDITION: COPD, Cancer (type)
V71.4	45,482	Encounter for examination following other accident	LOCATION: Anatomical location of the injury CONTEXT: Type of injury, how & where injured, sx CONCURRENT CONDITION: HIV, pregnant
511.9	42,354	Pleural effusion, not specified	LOCATION: known (pleural) CONTEXT: Symptoms, recurrent, onset CONCURRENT CONDITION: Cancer (type), CHF, TB, Lupus, Influenza or pneumonia, ESRD, Cirrhosis or liver disease

Analyze Code Volumes by Procedure

CPT CODE 73510
X-ray of the Hip, unilateral **Total Volume Billed 5405**

Billed ICD-9	Volume	Diagnostic Code Description	Additional Clinical Information for ICD-10-CM
719.45	3041	Pain in pelvic joint	LOCATION: Laterality CONTEXT: other symptoms (fever), timing, acute, chronic CONCURRENT CONDITIONS: Hip prosthesis, post-trauma
~~V71.4~~[1]	487	Observation for suspected condition	What symptoms raise suspicion for this condition?
715.95	468	Osteoarthrosis of the pelvic region, NOS	LOCATION: Laterality CONTEXT: Primary or post-trauma CONCURRENT CONDITIONS: Hip dysplasia or prosthesis
959.6	408	Injury to hip and thigh, not specified	LOCATION: Hip or thigh? Muscle or tendon? Laterality? CONTEXT: Type of injury (strain, contusion, puncture wound, foreign body), symptoms, or unconscious. TIMING: Initial, follow-up, sequela CONCURRENT CONDITIONS: Pregnant (LMP for trimester and gestation)

[1] These claims were denied due to medical necessity

TIP: Focus on top volume codes for:

- Communications to referring physicians
- Training for internal staff
- Redesigning referral or order forms to capture detailed indications

Sample Letter to Your Referring Physicians

Dear Dr. Jones,

The implementation deadline for ICD-10 is rapidly approaching. The new code set requires a higher degree of specificity in order to improve clinical outcomes and documentation. [*Sender's facility*] currently receives a high volume of non-specific indications from referring physicians. As we transition into ICD-10, we will be requesting more clinical detail *(as well as ICD-10 codes)* on the referral orders you send to us.

When ordering a study, consider including these additional details for the reason for the exam:

- **Location**: Please provide the specific anatomical location of the symptoms or condition (laterality, proximal or distal, quadrant, part of the lung, specific part of the bone, etc.).
- **Context**: Please include clinical information that provides context or explains "who, what, when, where, why, and how."
- **Associated or concurrent conditions**: Please state if there are any underlying or related diseases, or medical history, that is pertinent to the reason for exam. If the patient is pregnant, include the first day of their last menstrual period (LMP).
- **Injuries**: Please provide the date of the injury. It is helpful for us to understand if you are seeking a diagnostic interpretation for treatment decisions, status on the healing process, or an evaluation of a residual problem.

Providing this additional clinical information will allow us to provide better care and assessment or your patient. Please feel free to contact me with any questions.

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Redesigning Order Forms

ATTENDING PHYSICIAN

Physician Signature

SIGNS & SYMPTOMS

REASON FOR EXAM / HISTORY

Exam to be read by Radiologist?

DESIRED EXAM DATE & TIME

PT. NAME

BIRTH DATE

RESEARCH CONTACT & PHONE #

REFERRING DEPARTMENT

ORDERER NAME & PHONE #

Desired machine:

ICD-9: V 72.6 Research patient

INTERPRETER NEEDED

TRANSPORT

x	Svc Code	Description	x	Svc Code	Description	x	Svc Code	Description
		ASP, ABSCESS, BIOPSY, INJECTION			CT BODY / CARDIAC			
	5957753	CT ABSCESS PUNCTURE & ASP		5959055	CT CORONARY WO CALCIUM SCORE			
	5955165	CT ASPIRATION RENAL PERC		5959063	CT CORONARY W CALCIUM SCORE			
	5955173	CT BX ABD OR RETRO MASS		5959004	CT CARDIAC CALCIUM SCORING			
	5955181	CT BX BONE DEEP		5959152	CT HEART WWO W GATNG, 3D, EVL			
	5955190	CT BX BONE SUPERFICIAL		5959012	CT HEART WWO CONTRAST			
	5955203	CT BX LIVER		5959101	CT CARD STRUCT/CORONARY WO CS			
	5955211	CT BX LUNG		5959110	CT CARD STRUCT/CORONARY W CS			
	5955238	CT BX PANCREAS		5959128	CT CARD STRUCTUR W CONGENITAL			
	5949319	CT BX PELVIC ORGAN		5955289	CT CHEST W			
	5955246	CT BX PROSTATE		5955297	CT CHEST WO			
	5955254	CT BX RENAL LEFT		5955301	CT CHEST WWO			
	5955262	CT BX RENAL RIGHT		5955335	CT CTA CHEST WWO			
	5949408	CT FINE NEEDLE ASPIRATION		5955131	CT ABDOMEN W			
		CT HEAD & NECK		5955149	CT ABDOMEN WO			
	5955653	CT HEAD W		5955157	CT ABDOMEN WWO			CT UPPER EXTREMITY
	5955670	CT HEAD WO		5955327	CT CTA ABDOMEN WWO		5955513	CT UPPER EXTREMITY BILATERAL W
	5955688	CT HEAD WWO		5955319	CT CTA ABD RUN OFF WWO		5955521	CT UPPER EXTREMITY BILATERAL W
	5955343	CT CTA HEAD WWO		5955882	CT PELVIS W		5955530	CT UPPER EXTREMITY BILATERAL W
	5955696	CT IAC W		5955891	CT PELVIS WO		5955513	CT UPPER EXTREMITY LEFT W
	5955700	CT IAC WO		5955904	CT PELVIS WWO		5955521	CT UPPER EXTREMITY LEFT WO
	5955718	CT IAC WWO		5955386	CT CTA PELVIS WWO		5955530	CT UPPER EXTREMITY LEFT WWO
	5955858	CT ORBITS W		5957605	CT RENAL COLIC PELVIS WO		5955513	CT UPPER EXTREMITY RIGHT W
	5955866	CT ORBITS WO		5957613	CT RENAL COLIC ABD LTD WO		5955521	CT UPPER EXTREMITY RIGHT WO
	5955874	CT ORBITS WWO					5955530	CT UPPER EXTREMITY RIGHT WWO
	5956013	CT SINUSES W					Please list portions of extremity to be imaged	
	5956021	CT SINUSES WO			CT LOWER EXTREMITY			
	5956030	CT SINUSES WWO		5955441	CT LOWER EXTREMITY BILATERAL W			
	5955769	CT NECK SOFT TISSE W		5955459	CT LOWER EXTREMITY BILATERAL WO			
	5955793	CT NECK SOFT TISSE WO		5955467	CT LOWER EXTREMITY BILATERAL WWO			
	5955823	CT NECK SOFT TISSE WWO		5955441	CT LOWER EXTREMITY LEFT W			
	5955378	CT NECK WWO		5955459	CT LOWER EXTREMITY LEFT WO			
		CT SPINE		5955467	CT LOWER EXTREMITY LEFT WWO			
	5956048	CT SPINE CERVICAL W		5955441	CT LOWER EXTREMITY RIGHT W			
	5956056	CT SPINE CERVICAL WO		5955459	CT LOWER EXTREMITY RIGHT WO			
	5956064	CT SPINE CERVICAL WWO		5955467	CT LOWER EXTREMITY RIGHT WWO			
	5956072	CT SPINE LUMBAR W		Please list portions of extremity to be imaged				
	5956081	CT SPINE LUMBAR WO						
	5956099	CT SPINE LUMBAR WWO						
	5956102	CT SPINE THORACIC W						

One generic order form will not work effectively for ICD-10.

Devote more space for collecting procedure and clinical details.

One Size Does Not Fit All

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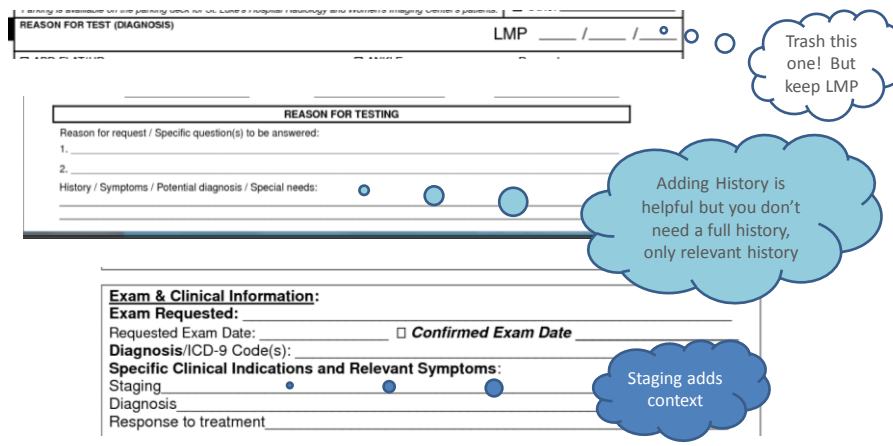
ICD-10-CM Code vs Clinical Descriptive Information?

- Will the ICD-10-CM code you receive be documented in the legal medical record?
- Code selection varies amongst coders, even some selecting inaccurate codes. That inaccuracy rate will likely increase with ICD-10-CM.
- Do you know who is selecting the ICD-10-CM code? Is it the ordering physician, a nurse, a scheduler, or a coder who has ICD-10-CM proficiency certification?
- Are you willing to trust somebody else providing an accurate code? Keep in mind, the billing provider is responsible for appropriate services for appropriate medical reasons.
- If you don't receive clinical information, how can you confirm the ICD-10-CM code?

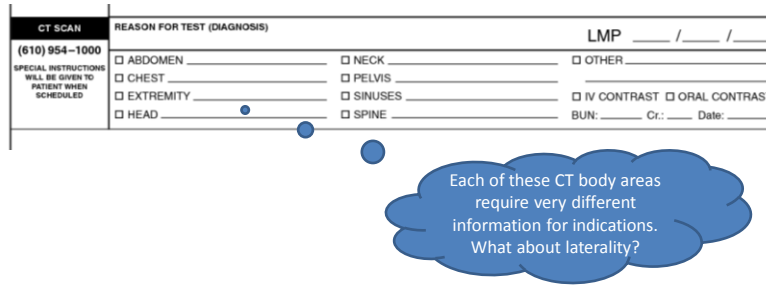
Start NOW

- Evaluate order systems and forms



Start NOW

- Evaluate order forms.



- Ask more specific, leading questions versus providing a free text area.
- Provide scheduling tools to front desk staff taking orders by telephone.
- Consider basing order forms and tools on the study ordered.

Where to Focus?

- Referring physicians:
  - Revamp order forms
  - Request patient medical records, e.g. history and physician exam notes
  - Canned questions for the schedulers to ask (general and specific to top-ordered procedures)
- Emergency room
  - How will your radiology department get the information from the ER?
  - Gather the clinical details after the exam?
  - Collaborate with ER management staff
- Patient and/or caregiver:
  - Check-in: Symptom and history forms
  - Empower technologists to interview and document patient's chief complaints!

Patient and Caregivers

Create check-in forms to gather details of the patient's chief complaint and history.

General form vs. specific forms for high volume procedures?

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

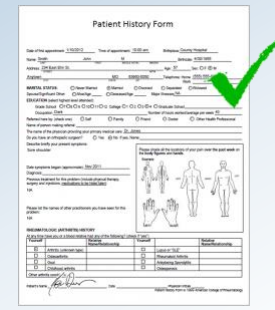
- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?

_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%

- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain |—————|—————| Unbearable Pain
0 5 10

The patient is a great resource for telling you why they are presenting for a radiologic exam!



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Revamp Current Forms and Worksheets

What missing details could be added to this Mammogram Worksheet?

Name (Last)_____(First)_____(M)___ | **MAMMOGRAM PATIENT HISTORY FORM**

DOB _____ Sex: _____M _____F

Why are you having this mammogram? (Mark one)

____Screening
____Lump or Thickening
____Skin Changes or Retraction
____Pain (Chronic or New)
____3 or 6 Months Follow-Up
____Nipple Discharge (please note color of discharges _____)
____Breast Implant problem
____Other (please specify _____)

Have you ever had a mammogram? If yes, when: _____ where: _____ **YES NO**

Have you had any breast surgery or treatment? (Mark one) **YES NO**

Procedures:	Where:	When:	Results:
____Cyst Aspiration	right left	_____	_____
____Biopsies	right left	_____	_____
____Lumpectomy	right left	_____	_____
____Mastectomy	right left	_____	_____
____Radiation	right left	_____	
____Reduction	right left	_____	
____Implants	right left	_____	__saline __silicon __pre-pectoral __retro-pectoral

Have you or anyone in your family been diagnosed with breast cancer? **YES NO**

__Myself __Mother __Sister __Daughter __Grandmother __Aunt

At What Age? _____ _____ _____ _____ _____ _____

Do you, or have you used hormones replacement therapy? **YES NO**

__Estrogen __Provera __Premarin __Prempro __Tamoxifen

When? Started: _____Finished: _____Still Using? _____

Most of these indications require laterality

Expand Implant Section:
1. Current implant or history of implant removal?
2. What type of problem?

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Schedulers

Scheduler

- Education focusing on additional details that are needed from referring physicians
- Create tools or scripts on what to ask the referring physicians
- Ask patients to complete medical information forms at check-in

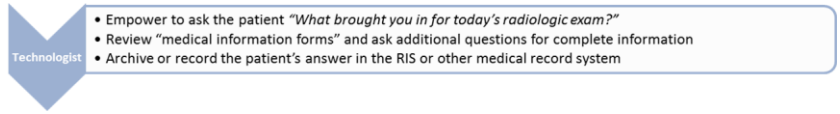
- Focus training on high volume procedures and frequently used diagnoses.
- Consider Medical Terminology and Anatomy 101 training. (KISS)
- Create canned questions to ask when scheduling exams by phone.
- Specific questions by procedures:

  We create specific prep instructions by exam type, why not scheduling questions to gather pertinent clinical information?

Questions for Abdominal Exams

Abdominal Pain:
Ask about specific site of pain (quadrant, generalized, epigastric, periumbilical, etc.)
Ask about context of pain (sudden, chronic, stabbing, colicky, after eating, etc.)
Ask about severity of pain (pain scale on 1 to 10. Ten being unbearable)
Ask about duration of pain
Ask if there was any injury or related possible cause of pain
Ask if there are any related signs or symptoms (GI/GU symptoms, rigidity, rebound, etc.)
Ask if there is any associated disease/condition (GI/GU condition, cancer, etc.)

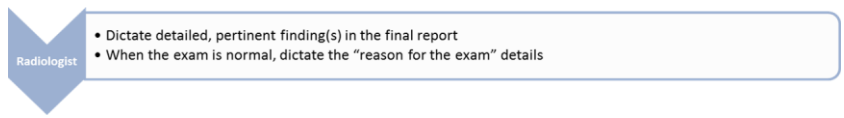
The Radiology Technologist



The radiology technologists play a critical role in the process! They are the last link between the patient and the interpreting radiologist.

- They have clinical knowledge and can gather pertinent clinical information.
- Customer service! When you ask about the patient's condition it makes the patient feel that you have their medical well-being at heart.
- Review the patient history form and ask for specific details that are missing.
- Good quality and pertinent medical information leads to better outcomes as the radiologist is better equipped to critically review the images.
- Training on ICD-10-CM for technologists is critical so that they understand what is needed!

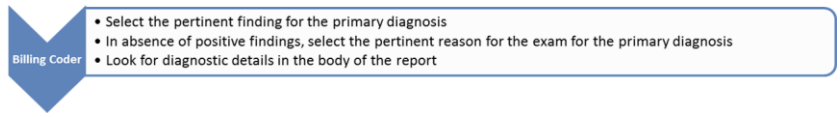
The Radiologist



By design, radiologists have to rely on referring physicians and others for clinical information about the patient. However, radiologists must document all pertinent positive findings.

- It will be the radiologist's responsibility to capture required details for positive findings.
- Radiologists cover a wide spectrum of clinical conditions in the scope of the services they provide.
- Education is a must!
- Coding tools will be important to their success.
- Audit now to provide feedback.

The Medical Coder



Codes selected for billing purposes must be supported by the medical record.

- Radiology coders typically do not have access to the patient's electronic medical record.
- Radiology coders rely on the final dictated report to code and bill radiology services.
- Codes for signs and symptoms should not be reported with a confirmed diagnosis if the symptoms are integral to the diagnosis.
- Training is critical. Certified coders must spend time studying the guidelines.
- Productivity will suffer: Practice, practice, practice. If they do not spend significant time using the new code set claims will be delayed. Duel code over the next few months!

Where to Find Missing Clinical Data?

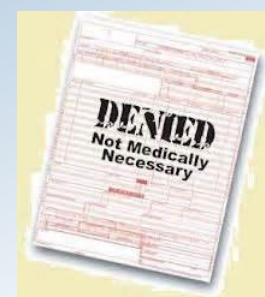
- Order or Scheduling management systems
- Patient medical records
- RIS or PACS for clinical history
- DICOM header tags
- Queries to the radiologists
- Queries to the facility performing the technical component
- Queries to the ordering physician

Training and Documentation Tools

Common Risks in Radiology

- Pain
  - Specific anatomical location
  - Severity or pain scale
  - Context (stabbing, with breathing, with activity)
  - Duration (onset, frequency)
  - Associated disease or condition
  - Related possible cause
- Injury
  - Timing:
    - During diagnostic or active treatment phase
    - During healing phase, or
    - Due to complication after end of treatment
  - What type of injury? (animal bite, contusion, laceration)
  - What anatomical area is involved?
  - Are there other associated symptoms? (foreign body, closed or open fracture, unconsciousness)

These common indications result in non-billable or denied services!

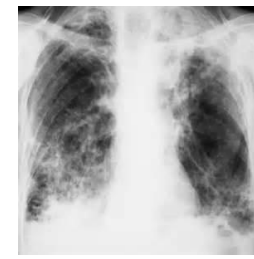


Common Risks in Radiology

- Fall (also see MVA)
  - Repeated falls
  - History of falling
- Motor Vehicle Accident (MVA)
  - What type of injury was sustained?
  - What part of the body was injured?
  - What symptoms is the patient experiencing?
  - Is the patient conscious?
  - Where and how?
  - Timing (during active treatment, during healing phase, or complication)
- Rule out, probable, suspicious 

- Pre-operative screening
  - Does the patient have a medical condition that increases intraoperative risk?
  - What type of surgery? Is it a cardiovascular or pulmonary procedure?

Pulmonary Fibrosis



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Capturing Details about Pain

Chest Pain:
Document specific site of pain (chest wall, intercostal, precordial, rt/lt sided, etc.)
Document context of pain (sudden, stabbing, with breathing, etc.)
Document severity of pain (pain scale)
Document duration of pain
Document any injury or related possible cause of pain
Document any related signs or symptoms (chest tightness, SOB, arm pain, etc.)
Document any associated disease/condition (COPD, cancer, etc.)

Abdominal Pain:
Document specific site of pain (quadrant, epigastric, generalized, periumbilical, etc.)
Document context of pain (sudden, chronic, stabbing, colicky, after eating, etc.)
Document severity of pain (pain scale)
Document duration of pain
Document any injury or related possible cause of pain
Document any related signs or symptoms (GI/GU symptoms, rigidity, rebound, etc.)
Document any associated disease/condition (GI/GU condition, cancer, etc.)

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Capturing Details about Pain

Limb Pain:
Document specific site of pain (RT/LT, upper/lower, site specific on arm/leg, etc.)
Document context of pain (sudden, at rest/exercise, radiating, etc.)
Document severity of pain (pain scale)
Document duration of pain
Document any injury or related possible cause of pain
Document any related signs or symptoms (numbness, cyanosis, tingling, etc.)
Document any associated disease/condition (arthritis, pathologic fractures, cancer, etc.)

Headache:
Document specific site of pain (frontal, temporal, facial, etc.)
Document context of pain (sudden, tension, cluster, migraine, throbbing, chronic, etc.)
Document severity of pain (pain scale)
Document duration of pain
Document any injury or related possible cause of pain
Document any related signs or symptoms (vision changes, sinusitis, etc.)
Document any associated disease/condition (neurologic condition, sinus, cancer, etc.)

Fractures: Documentation Tips and Classifications

DOCUMENTATION FOR FRACTURES	
Traumatic fracture	**Pathological fracture**
Anatomical location: (e.g. shaft, sternal end)	**Underlying cause** (neoplastic or osteoporosis)
Laterality: Right, Left, or Bilateral	What type of cancer?
Displaced or nondisplaced?	What type of osteoporosis? (e.g. age-related, idiopathic, drug-indcued)
Type of fracture (e.g. Greenstick, oblique, spiral, comminuted)	**Anatomical Locatio**n - which bone
Open or closed fracture?	**Laterality** (right, left, bilateral)
	Episode of care (Initial, subsequent, or sequela)
Episode of care (Initial, subsequent, or sequela)	**Subsequent radiology exams**, indicate one of the below:
ALL subsequent exams, (open and closed) indicate one of the below:	- Routine healing
- Routine healing	- Delayed healing
- Delayed healing	- Nonunion
- Nonunion	- Malunion
- Malunion	
For **open fracture subsequent exams**, include Gustilo Classification:	

GUISTILO CLASSIFICATIONS FOR OPEN FRACTURES	**EPISODE OF CARE**
Type I - Wound less than 1 cm with minimal soft tissue injury	**Initial** - Encounter for diagnosis or active treatment
Type II - Wound greater than 1 cm with moderate soft tissue injury	**Subsequent** - Routine care in the healing or recovery phase
Type III - Extensive damage to soft tissue	**Sequela** - Residual or late effect

Anderson and D'Alonzo Classification (DENS Fractures)
Type I - Oblique avulsion fracture of tip of odontoid. Due to avulsion of alar ligament.
Type II - Fracture through waist (high nonunion rate due to interruption of blood supply).
Type III - Fracture extends into cancellous body of C2 & involves a variable portion of the C1-C2 joint.

Grading Vertebral Injury: Spondylolisthesis

Spondylolisthesis is graded according to the degree that one vertebral body has slipped forward on another.
Grade I – Less than 25 percent slip
Grade II – Between 25 and 50 percent slip
Grade III – Between 50 and 75 percent slip
Grade IV – More than 75 percent slip
Grade V – Upper vertebral body has slid all the way forward off the front of the lower vertebral body. Very rare.

Asthma: Documentation Guidelines for Severity

ASTHMA SEVERITY CHART				
	INTERMITTENT	**MILD PERSISTENT**	**MODERATE PERSISTENT**	**SEVERE PERSISTENT**
SYMPTOMS	2 or less days per week	More than 2 days per week	Daily	Throughout the day
NITGHTTIME AWAKENINGS	2 x's per month or less	3 – 4 x's per month	More than once per week but not nightly	Nightly
RESCUE INHALER USE	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
INTERFERENCE WITH NORMAL ACTIVITY	None	Minor limitation	Some limitation	Extremely limited
LUNG FUNCTION	FEV1>80% predicted and normal between exacerbations	FEV1>80% predicted	FEV1 60 – 80% predicted	FEV1 less than 60% predicted

Other Classifications and Staging Tools

National Kidney Foundation KDOQI Stages of Chronic Kidney Disease:

CKD Stage	Description	GFR level (mL/min/1.73 m^2)
Stage 1	Signs of mild kidney disease with normal GFR	≥ 90
Stage 2	Mild kidney disease with reduced GFR	60-89
Stage 3	Moderate chronic renal insufficiency	30-59
Stage 4	Severely reduced kidney function	15-29
Stage 5	Very severe, or endstage kidney function	<15

Body Mass Index (BMI)	
Underweight	Below 18.5
Normal	18.5-24.9
Overweight	25.0-29.9
Obesity	30.0 and above

Documenting Ulcers

	Pressure Ulcer Stages
Stage 1	Skin changes limited to persistent focal edema
Stage 2	Abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
Stage 3	Full thickness skin loss involving damage or necrosis if subcutaneous tissue
Stage 4	With necrosis of soft tissues through to underlying muscle, tendon, or bone
Unstageable	Example: the ulcer is covered by eschar, treated with a skin or muscle graft, or documented as deep tissue injury but not documented as due to trauma.

NOTE: Document the site of the ulcer and laterality when it applies.
Document and code first any associated gangrene.

Non-Pressure Ulcers Severity
Limited to breakdown of skin
Fat layer exposed
Necrosis of muscle
Necrosis of bone

NOTE: Document the site of the ulcer and laterality when it applies.
Document and code first any associated gangrene.
Document and code first associated underlying conditions:

- Atherosclerosis of the lower extremity
- Chronic venous hypertension
- Diabetic ulcers
- Postphlebitic syndrome
- Postthrombotic syndrome
- Varicose ulcer

Pregnancy Studies

Trimester Designation	
First Trimester	Less than 14 weeks 0 days
Second Trimester	14 weeks 0 days to less than 28 weeks 0 days
Third Trimester	28 weeks 0 days until delivery

NOTE: Trimesters and gestational age are counted from the first day of the last menstrual period.

7th Character Extender to Designate Fetus Involved in the Condition	
0	Not applicable or unspecified
1	Fetus 1
2	Fetus 2
3	Fetus 3
4	Fetus 4
5	Fetus 5
9	Other fetus

Gestational age must be documented/calculated to select appropriate codes

Gestational Age Calculator - http://www.perinatology.com/calculators/Due-Date.htm

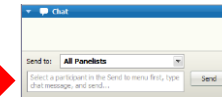
Resources

- *ICD-10-CM Official Guidelines for Coding and Reporting*, 2015; Centers for Disease Control and Prevention (CDC) website: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/icd10cm-guidelines-2015.pdf
- *2015 ICD-10-CM Complete Draft Code Set*; Optum Insight, Inc.
- CMS ICD-10 resources: http://www.cms.gov/Medicare/Coding/ICD10/index.html
- American Academy of Professional Coders Resources (AAPC) website: http://www.aapc.com

Thank You

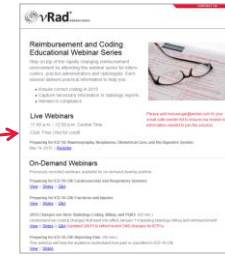
Please submit questions using Chat.

Enter question here



Answers, with supporting resources, will be posted on the webinar series webpage:

http://webinars.vrad.com/reimbursement_series



vRad team members with specific scenarios or questions are encouraged to contact Sharon Roeder for further support.